

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

AUTHORIZATION: I authorize: _____
(Name of person/entity disclosing information)

to use and disclose a copy of the specific health and medical information described below regarding:

(Name of patient) (Date of Birth)

Consisting of:

- | | |
|--|---|
| <input type="checkbox"/> Emergency & Urgent Care Records | <input type="checkbox"/> Physical Therapy Reports |
| <input type="checkbox"/> Hospital Inpatient Records | <input type="checkbox"/> Radiology / Diagnostic Imaging Reports |
| <input type="checkbox"/> Clinic / Outpatient Records | <input type="checkbox"/> Consultation / 3 rd Party Records |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Billing / Referral / Authorization Records |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Other _____ |

to: _____
(Name and address of recipient or class of recipients)

for the purpose of: _____

(Describe each purpose of disclosure)

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

- _____ HIV/AIDS information
_____ Mental health information
_____ Genetic testing information
_____ Drug/alcohol diagnosis, treatment, or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

PROVIDER INFORMATION You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization please send a written statement to Privacy Officer at Northwest Rheumatology Associates, 9155 SW Barnes Road, Suite 314, Portland, OR 97225 and state that you are revoking this authorization.

SIGNATURE I have read this authorization and I understand it.

Unless revoked, this authorization expires: _____
(Insert either applicable date or event)

By: _____ Date: _____
(Individual or Personal Representative)

Description of personal representative's authority:
